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ABSTRACT

Two working papers were presented at this meeting of the World Health Organization: "Principles and Methods of Health Education in the German Democratic Republic" and "A Philosophy of Health Education in Industrialized Societies." Both papers are summarized in this report. General and group discussions are presented along with conclusions and recommendations made by the organization. (JD)

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Principles and Methods of Health Education

Report on a WHO Working Group

ED178491

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WHO WORKING GROUP ON PRINCIPLES AND METHODS OF HEALTH EDUCATION

Dresden, 24 – 28 October 1977

1. INTRODUCTION

In 1976 the Twenty-ninth World Health Assembly adopted resolution WHA29.20 in which it approved the Sixth General Programme of Work for the World Health Organization during the years 1978–1983. Under that programme health education and information of the public were to be promoted.

In the light of the above, the Regional Office for Europe of the World Health Organization, in collaboration with the Government of the German Democratic Republic, convened a Working Group on Principles and Methods of Health Education in Dresden, German Democratic Republic, from 24 to 28 October 1977.

On behalf of the Ministry of Public Health of the German Democratic Republic the participants were welcomed by Dr C.R. Münter, Chief, Department of Medical Institutes. The meeting was opened by Dr A.P. Woudenberg, Regional Officer for Health Education and Social Sciences, who addressed the participants on behalf of Dr Leo A. Kaprio, Regional Director, WHO Regional Office for Europe.

Dr F. Görres (German Democratic Republic) was elected Chairman of the Working Group and Dr D.A. Player (United Kingdom) acted as Rapporteur.

The list of participants from 13 Member States of the WHO European Region is shown in the Annex.

2. SCOPE AND PURPOSE

One of the principal objectives of WHO's Sixth General Programme of Work is to promote closer cooperation between health services and all other sectors concerned with health promotion, including social welfare services. A detailed objective is to promote health education and information of the public, with particular emphasis on the responsibility of the individual and

active community involvement. To reach this objective the World Health Organization will encourage countries to define and/or improve their health education policies; in this endeavour principles and methods of health education are fundamental. Since policies can be regarded as guiding principles, or as methods habitually or consistently used or adopted, the main task of the Working Group was to discuss the principles and methods of health education in a number of countries and try to identify common denominators, thereby strengthening the professionalization of health education practices in the Region.

Within the programme of the Regional Office for Europe for the promotion of health education, the present Working Group was a natural continuation of the Symposium on the Preparation of Health Personnel in Health Education, with Special Reference to Postgraduate Education Programmes (Cologne, 1974), and the Working Group on the Place of Health Education in Health Administration (Manchester, 1976). It was necessary, in a changing world, for the approach to health education to be responsive to change also. There was a continuing and vital need to conduct research and evaluation into the effectiveness and efficiency of health education, and thus help to convince the general public and the policy-makers of the value and importance of the subject.

3. WORKING PAPERS

Two working papers[a, b] prepared for the meeting are summarized in the following paragraphs.

3.1 Summary of *Principles and methods of health education in the German Democratic Republic*

In the German Democratic Republic the whole of society is responsible for health education and its relation to the main political tasks. This principle ensues from the societal end-function of socialism. The promotion, maintenance and restoration of health contribute to the realization of the citizens' right, as guaranteed by the Constitution, to have their health and working capacity protected.

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[a] **Lammel, R., et al.** *Principles and methods of health education in the German Democratic Republic* (document ICP/HED 004/6).

[b] **Tones, B.K.** *A philosophy of health education in industrialized societies* (document ICP/HED 004/7).

Unified planning and the organizational efficiency of health education throughout the country correspond to the idea of democratic centralism as the proven foundation for the construction, cohesion and activity of the socialist state.

Scientific methods of health education are required since the formation of the socialist society, including the development of the personality and its relationships, calls for various forms of educational work which must be carried out on a scientific basis.

The principles of the activating role of health education in mobilizing the population to protect its health is based on a recognition of the need for its active participation, and corresponds to the overall political concern of socialism to enable all citizens to shape their own existence in a conscious and creative manner.

Health services and medical science have a decisive role in the health education of society, based on their social function. Within the framework of specialized responsibility they have as objectives research into the laws and conditions governing health and sickness and the organization of health protection.

Differentiation of health education, and orientation according to target groups, is based on the knowledge of educational science concerning the target/content/method relationship. It takes into consideration people's differing health education requirements according to their age, sex, health status, living and working conditions, and levels of responsibility.

3.2 Summary of *A philosophy of health education in industrialized societies*

It would appear that curative medicine is incapable of making any major contribution to the solution of health problems in contemporary industrialized societies. Individual and social behaviour are involved to a significant extent in the etiology and management of these problems. Hence, health education would seem to be in a position to improve the health status of the community by producing relevant changes in people's behaviour.

Primary health education may prevent the onset of problems by modifying behaviours involved in the etiology of disease processes; secondary health education is concerned with promoting early diagnosis and treatment; tertiary health education has to do with maximizing existing potential once irreversible damage has resulted from disease or degeneration. At each level of prevention, health education has a major part to play in promoting the development and proper use of relevant services. Early intervention should be a key goal.

The question arises whether health education should operate within existing health services, as part of the arsenal of preventive medicine, or resist being "medicalized". This issue is problematical as attempts to promote self-reliance, increased participation in community affairs and responsibility for individual and family health are based on an assumption

that people are in a position freely to choose what course of action they will adopt. However, the options open to an individual may be severely restricted by the powerful forces of socialization. Socialization is defined here as the process whereby informal knowledge, values, attitudes and routines are transmitted to individuals in society through social interaction. In one's "health career" various agencies and influences impinge on the developing individual from birth to death through various major phases of the life cycle, such as infancy, the school years, adolescence, parenthood, the mid-span years and retirement.

The influence of primary socialization appears to be paramount. A key principle of health education therefore is that of primacy, i.e. the earlier the intervention in the health career, the more effective the result. A second principle is that of specificity and authority: those who are perceived to have legitimate authority in certain issues will tend to have the greatest credibility, e.g., the doctor, the teacher, the social worker, but also the lay "opinion leader". Thirdly, there is the principle of integration: all these separate but overlapping influences should be coordinated in a systematic way. For this reason, health education needs a specialist to act as a consultant, a catalyst and coordinator in a community health education system.

Such a system should consist of two separate but coordinated sectors: one operating within the health care system, the other within the formal education system.

4. GENERAL DISCUSSION

Both working papers were elaborated by the authors and discussed by the Working Group in plenary sessions.

With regard to the principles of health education in the German Democratic Republic, it was stated that these could be formulated at different levels of abstraction and considered from various points of view, e.g., those of the behavioural sciences, communication theories, or social medicine. It was not thought possible to derive from one single science guidelines for planned and efficient health education on a nationwide level. Consequently, health education in the German Democratic Republic nad been based on the prevailing conditions of an advanced socialist society, on the findings of medical and other human sciences, and on laws influencing health-related behaviour.

It was stated that:

(a) the quality and effectiveness of health education could only be ensured when the principles on which it was based were considered in an overall framework and corresponded to the objective requirements in any country;

(b) if those principles were considered as guidelines, the possibilities for their implementation were determined by the relevant political, economic and cultural conditions of the country concerned, i.e., the principles should be adapted to the social conditions within which health education operated in a given country; and

(c) principles and methods of health education could not be separated unless under special conditions.

Health education experience in the German Democratic Republic corresponded with experience gained in other socialist countries and was developed in close collaboration with those countries, e.g., the USSR with its tradition of 50 years of scientific health education.

The methods of health education in the German Democratic Republic were based on the application of scientific findings made not in a vacuum but corresponding to society's interests.

Certain phases of planning and implementation of health education could be discerned in the German Democratic Republic. Decisions on the health-political key issues for health education to deal with were made not only by using the science of medicine, but were the result of all the social forces operating within the political situation. Following the preparation of the scientific foundations of health education, the specific share of the decisive social forces of education was prepared and immediately implemented. Evaluation of the progress reached took place at various levels in various social spheres over 5 to 10 years and the results were regularly generalized and re-evaluated. In that way health education in the German Democratic Republic had been developing since 1970 from an experimental undertaking into an integrated social task.

The author of the paper on a philosophy of health education in industrialized societies stated that health education was justified because of the limited success of modern curative medicine to deal with contemporary health problems. Thus the importance of modifying health-related behaviour as a prophylactic measure in primary, secondary and tertiary prevention was obvious. Health- and disease-related habits were created during one's "health career" which was influenced from birth to death by the process of socialization. Health education should therefore aim at primary prevention of health problems at a very early age. Child-rearing practices might lead to the "deferred gratification ethic", rejecting an at-risk role but adopting a preventive behavioural approach: "Pay now, live later (and longer)".

Self-esteem was closely related to child-rearing practices. High self-esteem increased the capacity to resist group pressures later in life. The influence of secondary socialization agencies such as the school was much less powerful. Health education efforts directed at resocialization, often at a relatively late stage, frequently had no noticeable success.

It was argued that health education in the industrialized countries differed from that in the less-industrialized countries, where prevailing health problems were surmountable by curative medicine. In industrialized societies, however, human behaviour was preponderant in the causation and solution of major health problems. Also in the industrialized societies there was a wide range of different value systems and subcultural beliefs which made consecutive health education action very difficult.

It was also argued that medicine over the past 200 years had contributed little to the health of the community but rather to individual health. The health of the community had improved through better general hygiene and housing, better nutrition, and through family planning and maternal and child health services.

It would appear therefore that health education in the sense of planned attempts to influence health-related behaviour was much needed in many countries. Training in health education was equally required but often not adequately provided for in curricula for medical students, nor in postgraduate training of physicians or other professionals who could assume the role of health education specialist/catalyst/coordinator/consultant/evaluator.

In the subsequent discussion it was stated that in the USSR positive results were obtained by systematically training health personnel to become specialized in health education. There were also provisions for health education training in the curricula of medical students in the USSR.

In the United Kingdom there was a health education component built into the medical undergraduate and postgraduate training in health education up to Master of Public Health level (medical schools of Dundee, Edinburgh and Manchester). There was also a "cross-fertilization" by having lectureships in different disciplines in various departments, e.g., medicine, education, psychology, social administration, preventive dentistry, nursing, etc.

In connexion with the above the following was quoted from a WHO Regional Office for Europe report:[a]

"The Working Group agreed from the outset that it is not possible to produce a recommendation of one "best" model of health education services, in the same way that there is no "best" way of organizing the health care of a nation. Health education must be organized to fit the value system, organizational structure and health problems of each country in the Region.

"As far as the value system is concerned, it is reflected in a country's sociopolitical subsystem. It can range from an individual to a communal approach, with various combinations of both in between. This will also influence the way any changes will be achieved if they should be deemed necessary. In some countries the emphasis will be on a gradual evolvement of

[a] *The place of health education in health administration. Report on a Working Group, Manchester, 29 March – 1 April 1976.* Copenhagen, 1977 (ICP/HED 003).

awareness among politicians and administrators that the future health of the people depends on a successful and developed health education service; in other countries the change will be achieved through legislation and pressure to reduce the gap between top-level decisions and field-level implementation.

"The existing organizational structures of the teaching institutions as well as the services will represent a further constraint on the development of health education. There are countries where health education is not a recognized subject in the teaching institutions. Even when the body of knowledge becomes academically respectable, it will be necessary to understand and take into consideration the procedures in such institutions that can be utilized in gaining acceptance of a new subject. The same applies to the existing organizational structure of the health services in a country. To avoid the sad situation where the need for health education only receives occasional lip-service from administrators and politicians, it is necessary to make definite provision for a career structure and job definition for health education agents. Where no specialists are being envisaged, the duties of existing agents must be spelled out, included in their job definition and even included in their contracts where this applies."

Attention was also drawn to a recommendation in another Regional Office report[a] about stimulating and promoting the preparation of health personnel in health education, with special reference to postgraduate training.

Several participants referred to Illich's criticism[b] of the educational and medical systems but felt there was no reason for undue pessimism about the functioning of either, and certainly not of medicine in general. With regard to the role of medicine in health education it was considered desirable to delineate more precisely what actually represented a health education problem. It seemed that health professionals were too often asked to solve problems which were outside their realm. It would not appear feasible to expect specialists, such as anaesthesiologists or neurosurgeons, to undertake much health education when they were not trained to do so, and the functions of individual physicians and those of health care systems vis-à-vis health education should not be confused. In other words: if the health care system did not provide for health education, it could not be expected that individual physicians should do so of their own accord.

Regarding the role of the general practitioner or medical specialist, it was stated that, generally speaking, people carry out best the tasks they

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[a] *The preparation of health personnel in health education, with special reference to postgraduate education programmes. Report on a Symposium, Cologne, 10–14 November 1974.* Copenhagen, 1975 (EURO 4503).

[b] **Illich, I.** *Medical nemesis: the expropriation of health.* London, Calder and Boyars, 1974.

like, and feel capable of handling. That applied also to physicians. Since they had been traditionally trained and become skilled and motivated to provide curative services but not so trained with regard to health education, they would from a pragmatic point of view consider health education an unwelcome burden.

One course of action therefore would be to train health education specialists as coordinators, and to regard health education as a new multidisciplinary science. That raised the question of how to train an all-round health educator, and also whether a health care system could afford to have an apparently large number of health education coordinators. Thus the responsibility for health education should be placed at grass-root levels, i.e., with society, in which every individual was responsible for his or her own health and that of the community.

However, that was generally agreed to be too big a task for the individual, who therefore needed support from the health personnel who, in their turn, would then need coordination of their efforts by a health education specialist. That was essentially the way in which health education was carried out in socialist countries and it could be argued that the same would apply to nonsocialist countries as well.

On the other hand, since many patients were motivated to receive health education from physicians, it would seem desirable that physicians would provide at least some of it. Their training in health education could perhaps come under the subjects of social medicine or community medicine.

An example was given of a 20-hour course in community health for medical students in Finland dealing with health-related behaviour and methods of health education. The students also had to carry out a small-scale health education programme. In that way medical students became aware of health-related behaviour, and sensitized to health education. The physician would not have a role in primary health education since no patients were involved, but in secondary and tertiary prevention he would provide basic health education services and accept the coordination (identification of problems, planning, evaluation of programmes) of the health education specialist. The latter did not need to be a physician but, for example, a communication scientist.

One participant commented that courses in health education for medical students only motivated further the already-motivated students but not the nonmotivated ones. That had been a conclusion from a study in a university medical school in the USA some two years earlier. It would seem therefore that the philosophy of health education and preventive medicine should permeate first the whole faculty of a medical school in order to change the mentality, attitude and outlook of the students. That would be a political issue, i.e., a problem for those responsible for medical education as well as a task for the students themselves to make the point clear to the universities. The problem was, however, surmountable, by making proper choices from all the possibilities society had available and carefully neutralizing or avoiding negative choices.

Another participant said that in his country health education had been operating in isolation from the objectives of health, educational and social welfare policies. One of the main principles of health education would therefore be to integrate the health education objectives with those of general social policy. Lack of health education objectives would in itself make evaluation of the effect of its activities very difficult if not impossible, and would leave health education to continue on a traditional basis without analysing actual needs.

Legislation also had a very important if not dominant role to play. For example: trying to persuade people to consume less fat was useless if the legislators left the price of high-fat milk the same as that of low-fat milk. An effective anti-smoking law would be worth hundreds of years of health education. Creating a legislative framework for health education was considered to be by far the most important aspect for nationwide health education.

The general discussion showed that there were a number of parallel ideas in both papers worthy of elaboration. The Working Group therefore divided into three subgroups to discuss the need for health education specialists, the role of the physician and the health team in health education, and the relationship between health and education.

5. GROUP DISCUSSIONS

5.1 The need for health education specialists

It was stated that in the United Kingdom a health education specialist was needed to act as a coordinator, promoter and catalyst of health education activities in the community, in an integrated system by which people were influenced throughout life with regard to health promotion.

Basically those influences originated from the mass media and from interpersonal contacts. The mass media were capable of reinforcing information, values and habits, and through interpersonal contact habits, motives and values could be changed.

Interpersonal contacts with regard to health education took place between health personnel and client at several levels: in school and during further formal education, through voluntary agencies promoting the health of the community, and also through "lay influence".

A local or regional health education specialist should coordinate all those influences and inputs and ensure that all agencies and persons concerned carried out the tasks they were most committed to and best equipped for in terms of methods. For example, a nurse in a well-baby clinic was in a good

position to talk with the mother about early habit-forming of the child; the schoolteacher to provide knowledge and understanding about health matters. Those overlapping roles meant that the health education specialist was needed to coordinate the various inputs. He was also needed as a catalyst to make the community aware of who and where the persons and agencies were that could effectively promote health.

To carry out those tasks adequately the health education specialist should possess the appropriate skills and knowledge. He did not need to be a medical specialist, but rather one trained in communication and behavioural sciences in order to advise those who were carrying out the face-to-face health education; that would not preclude a medical or other person with a good training in education and communication methods and techniques.

In the socialist countries the health education specialist was usually a physician who specialized in public health, and had had training in health education. But nurses, educators and psychologists also worked in health education within the framework of the health care system. The health education specialists were not autonomous coordinators, since coordination of health work was a responsibility of governmental agencies. They were rather seen as holding an important function in supporting the health and education personnel who were in direct contact with the population.

The health education specialist in socialist countries usually worked at district level and was also a manager and coordinator of his staff, integrated in the public health system.

The subgroup considered that the health education specialist (or perhaps he should be called "expert") was not necessarily a central figure operating autonomously. That would depend on where he would work, i.e., in a particular social, cultural and public health system prevailing in a country. The nature of the task would not make the health education expert autonomous but would put him in a central position in a communication network. Most important was his function, the core of which was to apply behavioural sciences to the solution of disease problems and the promotion of health, using various educational and behavioural change techniques. It was agreed that a health education specialist was needed to ensure the quality and efficiency of health education activities. He should work within or in close connexion with the health services system. His function was to stimulate and organize health education activities, to advise on methodology, coordinate, and act as a catalyst. He should concentrate on guidance and support of key figures, such as physicians and teachers, as well as on voluntary health agencies, occupational health activities and the mass media.

The health education specialist should have a good medical knowledge, particularly in preventive medicine, as well as skills and abilities in the application of behavioural sciences in medicine and public health (particularly psychology, educational techniques and methods, and communication

science). In addition, he should be trained in management, planning, organization, methodology and evaluation of health education activities.

The existence of health education specialists would not absolve society or governments of responsibility for the health and health education of a population, or health and educational personnel for carrying out health education activities.

It was also agreed that the role, function and place of a health education specialist was determined by the political, cultural and social system of a given country. More information was needed to find common denominators on those issues.

The subgroup concluded that the principles of health education laid down in the first working paper were generally acceptable and applicable. Although no ranking order of the six principles was recommended, it was thought that the first one mentioned was the guiding principle. It was also thought useful to state explicitly that evaluation of health education activities was an intrinsic ingredient of the principle on the scientific nature of health education.

Finally, the subgroup emphasized the need for further studies into the methodology of health education, especially with regard to individual methods (face-to-face), group work, and mass communication.

5.2 The role of the physician and the health team in health education

In discussing that subject the second subgroup identified two main roles, i.e., providing a medical-scientific basis for health education, and acting as health educators and advisers to patients singly and in groups, to the community at various levels, and as consultants to other professions. The second main role was examined in depth and considered in the light of primary, secondary and tertiary health education.

The members of a health team would include a public health nurse, a hospital nurse, a general practitioner, a medical specialist, a health education specialist and a public health administrator/community physician.

It was considered necessary to have in most countries a limited number of public health administrators working full-time in health education. They would have an important role to play in advising on health education policy at central level. Public health administrators, even if involved only part-time in health education, were needed also at local level to play a role in an advisory capacity as regards health legislation.

The health education specialist's role was not discussed by the second subgroup as it agreed to accept the conclusions and recommendations of the first subgroup.

There were two main types of medical specialist: those who were in contact with patients (e.g., paediatricians, gynaecologists), and those who were not (e.g., pathologists). All those in contact with patients had a very important role to play in tertiary health education.

The general practitioner's most important role was in primary health education, where he could give a personal example, be a catalyst in the community, or teach health education in schools and factories, etc. He also had a role in secondary health education by developing screening programmes for early diagnosis and advising his patients.

The hospital nurse's role was mainly geared to secondary and tertiary health education, and that of the public health nurse to primary health education, although also to secondary and tertiary.

The role of the paramedical professions in health education (e.g., occupational therapists, physiotherapists), was not considered in detail.

The question then arose of how the physician and other members of the health team could be motivated to fulfil their role in health education. At a practical level the provision of teaching aids and health education materials would help to increase the effectiveness of health education by health personnel.

The development of training and instruction of health personnel in health education at undergraduate and postgraduate levels, in line with the recommendations of a Regional Office report,[a] would create within the health professions an understanding of health education and of its importance in the health care system.

A better status and recognition should be given to health professionals specializing in health education. Using health education methods was thought to be of self-interest to physicians since they would eventually reduce their total workload with more rewarding results.

By involving the health team in health education policy-making at all levels, and by involving the community in planning health education strategies, both the physician and the community would be motivated to participate in health education activities. Evaluation studies at local level would lead to a positive feedback.

The subgroup was of the opinion that governments should strongly support health education in order to achieve a more health-oriented society in general. Specific legislation would reinforce health education efforts.

The subgroup accepted the six principles of health education mentioned in the first working paper as generally applicable. At the same time it was realized and recommended that in order to apply those principles a community health education system was needed within which health educators and health education specialists would operate. Therefore training in health education of health personnel, as well as other professions, was required at all levels, as indicated in the Regional Office report mentioned previously.

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[a] *The preparation of health personnel in health education, with special reference to postgraduate education programmes. Report on a Symposium, Cologne, 10–14 November 1974.* Copenhagen, 1975 (EURO 4503).

Finally, the subgroup recommended training in heath education management skills, including any necessary training in behavioural sciences of those in charge of national policy-making in health education (such as directors of health education institutes or those with a similar leading function), possibly with the assistance of the Regional Office for Europe.

5.3 The relationship between health and education

On this subject, the third subgroup presented its conclusions and recommendations as follows.

The state, and society as a whole, carried responsibility for health education, since health knowledge should form part of every individual's cultural background and health education should be an integral element of general education, aimed at improving the quality of life.

The educational component in planning and executing national programmes concerned with health must be integrated on a regular basis and applied in a specific manner.

In establishing health education objectives, the first essential was to study the population to be covered and to arrive at a precise determination of its health needs: those expressed, those felt, and those determined by the health services as essential to provide minimum conditions.

Health education must be planned systematically so as to permit all those involved in developing and maintaining individual and community welfare to participate.

If health education methods were to be improved, scientific research on the subject must be undertaken so as to arrive at an accurate verification of methods and indicators which would make evaluation of health education activities possible.

An all-round approach using every available educational technique must be employed at the earliest possible age in order to improve an individual's awareness of health matters and health-related behaviour, including sexual behaviour.

It was essential to ensure the participation of individuals and the community in taking care of their health. That was the ultimate goal of the educational process.

All individuals and all responsible organizations possessing authority in the educational sphere must allocate a major priority to health education.

Health education must be based on existing conditions and must be in line with, on the one hand, the socioeconomic and cultural reality of society, and, on the other, with the progress and scientific trends in medicine.

All medically oriented activities carried out by health teams must bring about, integrate and develop health education, which must be an integral part of all medical and social action.

Every effort must be made to integrate health education into the individual educational process by making use of and modifying already proven existing educational methods and techniques and by carrying out research into new health education methods.

Multidisciplinary collaboration and research must be developed so as to draw up and use a methodology which was specific, scientific, practical and suitable. Such a methodology would permit the development of health education applicable in varying circumstances.

6. RENEWED GENERAL DISCUSSION

The Working Group noted that the reports of the three subgroups were to a great extent similar as to their conclusions and recommendations.

The six principles of health education discussed in the Working Group were unanimously adopted by the participants. The principle mentioned first was considered as the guiding one.

The Working Group stressed the importance of international contacts in health education in order to exchange information and experience. It endorsed the efforts of the Regional Office for Europe to strengthen its relations and collaboration with governmental and nongovernmental agencies directly or indirectly involved in health education.

It was considered essential that legislation should support health education policy and plans. For example: a health education programme on healthy nutrition would hopefully be supported by legislation regarding the production and sale of food with a high fat content. Similarly, legislation was desirable concerning the use of safety belts in automobiles, and banning or restricting the advertising of tobacco and alcoholic products.

Legislation was seen as a corollary of the leading principle of society's responsibility for health education. The credibility and effectiveness of health education would gain enormously by being provided with a legal background and framework.

7. CONCLUSIONS AND RECOMMENDATIONS

The Working Group agreed that the principles of health education had been adequately covered during the meeting but that health education methodology required further and consistent attention.

The participants concluded that:

- the community as a whole must take responsibility for health education and its relation to the main tasks of society;
- health education should be organized in an efficient and planned fashion;
- health education should be founded on a scientific basis, its methods should be scientifically tested and evaluated, and in order to achieve this, research into health-related behaviour is required;
- health education should activate the population to protect its health and enhance personal responsibility for health;
- there is a special role for medicine and the health service in health education;
- health education should be differentiated and oriented according to target groups.

On the basis of these conclusions, which can be regarded as the principles of health education, the Working Group recommended that the WHO Regional Office for Europe should:

- draw the attention of the governments of the Member States of the Region to the importance of basing theoretical and practical work in health education on these principles, especially in connexion with the planning, organization and direction of health education measures at the national level; consumer participation and the role of legislation in health education were considered to be important in this connexion;
- promote the exchange of experience in the training, development and activities of health education specialists in the Member States of the Region; a study of the training needs in health education of various professional groups (including medical students) was considered to be desirable;
- collaborate closely with nongovernmental organizations in the field of health education (such as the Europa Bureau of the International Union for Health Education);
- stress the importance of the systematic development of health education methodology.

Annex

LIST OF PARTICIPANTS

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